Duty Status Report

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.) and is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No.: 1215-0103
Expires: 10-31-99

2. OWCP File Number (If known)

SIDE A - Supervisor: Complete this side and refer to physician

1. Employee's name (Last, first, middle)

2. Date of injury (Month, day, yr.) | 3. Social Security No.

4. Occupation

5. Describe How the Injury Occurred and State Parts of the Body Affected.

6. The Employee Works
Hours Per Day Days Per Week

7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or Intermittently, and Give Number of Hours.

Activity	Continuous	Intermittent	
a. Lifting/Carrying: State Max. Wt.	#lbs.	#lbs.	Hrs Per Day
b. Sitting			Hrs Per Day
c. Standing			Hrs Per Day
d. Walking			Hrs Per Day
e. Climbing			Hrs Per Day
f. Kneeling			Hrs Per Day
g. Bending/Stooping			Hrs Per Day
h. Twisting			Hrs Per Day
i. Pulling/Pushing			Hrs Per Day
j. Simple Grasping			Hrs Per Day
k. Fine Manipulation (includes keyboarding)			Hrs Per Day
l. Reaching above Shoulder			Hrs Per Day
m. Driving a Vehicle (Specify)			Hrs Per Day
n. Operating Machinery (Specify)			Hrs Per Day
o. Temp. Extremes			Range in degrees F
p. High Humidity			Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)			Hrs Per Day
r. Fumes/Dust (Identify)			Hrs Per Day
s. Noise (Give dBA)			dBA Hrs Per Day
t. Other (Describe)			

SIDE B - Physician: Complete this side

8. Does the History of Injury Given to You by the Employee Correspond to That Shown in Item 5? ☐ Yes ☐ No (If not, describe)

9. Description of Clinical Findings

10. Diagnosis Due to Injury | 11. Other Disabling Conditions

12. Employee Advised to Resume Work?
☐ Yes Advised _____ ☐ No

13. Employee Able to Perform Regular Work Described on Side A?
☐ Yes, If so ☐ Full-Time or ☐ Part-Time Hrs Per Day
☐ No, If not, complete below.

Continuous	Intermittent	
#lbs.	#lbs.	Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Range in degrees F
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		dBA Hrs Per Day

14. Are Interpersonal Relations Affected Because of A Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) ☐ Yes ☐ No (Describe)

15. Date of Examination | 16. Date of Next Appointment

17. Specialty | 18. Tax Identification Number

19. Physician's Signature | 20. Date

SUPERVISOR: Complete Side A and refer the form to the physician to complete Side B. Fill in the address of the Employing Agency and the appropriate OWCP District Office in the spaces below. Enter the OWCP file number in the top right corner.

PHYSICIAN: Complete Side B, sign and return to the employing agency within 2 days to prevent interruption of the employee's income Fill in your name and address.

Medical Facilitv Name and Address

Send Original Report to:

Employing Agency Address

Send A Copy of This Report to:

Employing Agency Address

CERTIFICATION: BY SIGNING BLOCK 19 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-17 ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPRESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

I FURTHER UNDERSTAND THAT THIS REQUEST DOES NOT CONSTITUTE AUTHORIZATION FOR PAYMENT OF MEDICAL EXPENSES BY THE DEPARTMENT OF LABOR, NOR DOES IT INVALIDATE ANY PREVIOUS AUTHORIZATION ISSUED IN THIS CASE.

Public Burden Statement

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this estimate or any other aspect of this information collection, including suggestions for reducing this burden, send them to the Office of Workers' Compensation Programs, U.S. Department of Labor, Room S-3229, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

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DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

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